Small Assisted Living Programs Study Recommendations Report

January 2024

House Bill 636/Senate Bill 531 (2022)
Report to the Legislature

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I. Purpose of Report on Small AL Programs in Maryland

Under Maryland's Senate Bill 531/House Bill 636 legislation[1], the Maryland Health Care Commission (MHCC or "Commission") in consultation with the Office of Health Care Quality (OHCQ), the Maryland Long-Term Care Ombudsman Program, the Medicaid Administration, the Governor's Workforce Development Board, and interested stakeholders, is required to conduct a study regarding the quality of care by assisted living (AL) programs with nine or fewer beds in the state. By December 1, 2023, the Commission is required to report its recommendations, including any draft legislation, to the Governor, the Maryland Department of Health, and certain committees of the General Assembly.

The study shall incorporate the following Study Questions:

a. An analysis of inspection data from the Office of Health Care Quality to determine, on a systemic level, where regulatory oversight and quality of care may be improved;
b. An examination of the entry into and exit from the market for AL programs, including any noticeable trends related to inspection data or regulatory requirements;
c. A consideration of the feasibility of developing a reporting system for assisted living programs that protects patient confidentiality and makes data related to catastrophic health emergencies declared by the Governor and quality of care publicly available;
d. A review of current assisted living program licensure regulations to determine whether these programs should be regulated differently than programs with ten or more beds;
e. A determination as to whether: (1) AL programs receive sufficient reimbursement to cover the cost of care for the services provided, including for residents with Alzheimer's and other dementia-related conditions, under initiatives offered through the Maryland Medicaid Administration or other State or local initiatives; and (2) the Home-and-Community-Based Options Waiver, or any other waiver program that may be used for AL programs, can be revised to improve the quality of care, and increase provider participation;
f. A review of staffing resources that could be better utilized and made available for these programs, including measures to encourage the recruitment and retention of staff and meet standards for sufficient staffing.

[1] The full text of the bill is available in Appendix A.

II. National and State Trends in Assisted Living

AL programs refer to specialized services and facilities designed to support individuals who require assistance with their activities of daily living and may benefit from additional healthcare services. These programs provide a combination of housing, personal care, social activities, and limited medical support to enhance the overall well-being and independence of the residents. AL programs often help with tasks such as bathing, dressing, medication management, meal preparation, and transportation. The objective of AL programs is to create a supportive and comfortable environment that promotes individual autonomy while ensuring necessary support and supervision are readily available.

AL programs are recognized as one of the fastest growing components of the long-term care industry. Nationwide, there are an extensive number of AL programs, totaling 30,600 programs. These programs offer a combined sum of 1,197,600 licensed beds/units, with an average of 39 beds/units per program.[4] Per the American Health Care Association/National Center for Assisted Living, 56% of AL programs are chain-affiliated (an organization with two or more communities), and 42% are independently owned. The remainder are government owned.

Per the Office of Health Care Quality, in June 2023 there were over 1,706 AL programs with 25,900 licensed beds in Maryland.[2-3] 77% of these programs were licensed for nine or fewer beds. The number of programs fluctuates and changes daily. Jurisdictions with the largest number of licensed programs are in the center of the state in Baltimore City (535 Programs), Prince George's County (303 Programs), Montgomery County (231 Programs), Baltimore County (151 Programs) and Anne Arundel County (133 Programs). These five jurisdictions account for over 79% of all licensed programs in Maryland, with 17,802 licensed beds. Approximately 83% of the licensed programs in these five jurisdictions have nine beds or fewer (6,140 beds). As of June 2023, Somerset and Garrett Counties did not

[2] The differences observed between the numbers provided by the National Center for Assisted Living (NCAL) and the Office of Health Care Quality (OHCQ) may be attributed to various factors. These could include differences in the criteria used to define and categorize assisted living communities, variations in data collection methodologies, or differences in the time frames considered. It is essential to consult with both organizations and refer to their specific methodologies for a more accurate understanding of these differences.

[3] Office of Health Care Quality (2023). Summary of AL programs in Maryland. Provided to MHCC staff on August 4,2023 via email.

have any AL programs with nine or fewer beds, while almost all (93.4%) of Prince George's County's AL programs consisted of programs with nine or fewer beds (54% of beds). There were 7,156 direct jobs and 9,916 total jobs (direct, indirect, and induced effects on the economy of the state), $637.7 million and $1.12 billion dollars spent and $50.6 million in state and local tax revenue and $103.9 million in federal tax revenue.[4]

AL programs vary widely in size, influenced by factors such as the nature of the program, its geographic location, and the level of care provided. They can range from small homes accommodating 2 or 3 residents to expansive establishments housing several hundred residents. The appeal of smaller facilities is their cozy, homelike environment, which allows for personalized care and attention. In contrast, larger facilities often boast a variety of amenities, from extensive recreational areas and diverse dining options to added conveniences like fitness centers, beauty parlors, and libraries. Regardless of size, both types of programs can deliver excellent care tailored to their residents. The choice between a smaller or larger program often hinges on personal preferences, financial considerations, geographical convenience, and the specific needs of the resident seeking assisted living services.

A. Changing Maryland Demographics

As of 2020, individuals aged 60 and above constitute 20.6% of Maryland's population, a percentage projected to rise to 26.6% by 2040. Particularly, the demographic segment over the age of 85 is anticipated to experience the most significant growth, with projections indicating an increase of 158% by 2045. Additionally, over the next three decades, a shift in the geographical distribution of this aging demographic is expected. Baltimore City registers the highest population of low-income older adults from minority backgrounds, with Prince George's and Montgomery counties trailing closely. Notably, rural counties such as Allegany, Caroline, Dorchester, Garrett, and Somerset, also host a substantial number of low-income elderly residents.

Based on estimates for 2020, approximately 62.8% of older adults (aged 60 and above) in Maryland are projected to reside in Baltimore City and the counties of Anne Arundel, Baltimore, Montgomery, and Prince George's. In 2035, while these regions are still predicted to host the most significant numbers of the 60-and-over demographic, counties

[4] Maryland Department of Aging (2021) State Plan on Aging 2022-2025. Retrieved from: https://aging.maryland.gov/SiteAssets/Pages/StatePlanonAging/MD%20State%20Plan%202022-2025.pdf

like Carroll, Cecil, Charles, Frederick, Howard, and St. Mary's are anticipated to record the steepest percentage growths in their senior populations.

B. AL Programs in Maryland (Study Question D)

In the state of Maryland, an assisted living program is specifically defined as “a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of individuals who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the individuals” (COMAR 10.07.14.02B(11)a-b). This definition outlines the comprehensive approach taken within the state to ensure the well-being and autonomy of residents requiring specialized care.

In Maryland, assisted living program providers cater to a wide array of preferences and necessities, ranging from expansive, professionally managed facilities housing numerous residents in individual apartments, to more intimate, privately-operated homes where several residents might share a room, with the owners directly providing care. What unites these varied setups is their core objective: assisting residents with day-to-day tasks such as dressing, bathing, eating, and other activities of daily living.

C. Variability in Definitions and Categorizations of Small AL Programs

Within the United States, state-specific definitions and terminologies present a challenge in standardizing what constitutes an "assisted living program" and, more specifically, a "small assisted living program." While there isn't a universally accepted definition, the National Institutes of Health's National Institute on Aging delineates "small" AL programs as those accommodating 20 or fewer residents.[5] This designation of "small" can differ from one state to another, with variations in nomenclature and criteria based on the number of beds or residents.

Understanding the diversity in definitions and categorizations across states is pivotal for contextualizing the landscape of small AL programs. Presented below in Table 1 are the specific definitions and categorizations adopted by various states for small AL programs.

[5] National Institutes of Health. National Institute on Aging. (2023) Residential Facilities, Assisted Living, and Nursing Homes. Retrieved from: https://www.nia.nih.gov/health/residential-facilities-assisted-living-and-nursing-homes

Table 1. States' Definitions and Categorization of Small AL Programs

State	Name for "Small" Program	Size/# Of Beds
Maryland	Small AL Programs	9 beds or fewer determined MHCC Survey parameter; 6 or 16 by the county departments of health
Minnesota	Assisted Living Program (w/Dementia)	10 beds or fewer
North Carolina	Small Assisted Living Program	2-6 beds
New Jersey	Assisted Living Residences or Comprehensive Personal Care Homes or AL Programs (part of publicly subsidized housing)	No min or max sizes based on population and services
Ohio	Adult Family Homes or Adult Group Homes or Residential Care Facilities-Assisted Living	3-5 beds 6-16 beds 17+ beds
Oregon	Residential Care Facilities or Assisted Living Facilities	1-151 1-151 (do not define small)
Washington State	Adult Family Homes or Assisted Living Facilities	2-6 beds 2+ beds
Wisconsin	Adult Family Homes or Community Based Residential Facilities	1-4 beds 5-257 beds

III. State-Driven Quality Initiatives in AL Programs: Innovations, Implementations, and Comparative Insights

A. Quality Improvement Initiatives in AL Programs: A Multi-State Overview

Research emphasizes the importance of assessing quality of life and resident satisfaction. Several states, including Minnesota, North Carolina, and Wisconsin, have implemented programs or regulations to ensure the quality of AL programs within their jurisdictions. These programs focus on assessing the quality of life for residents, utilizing quality

indicators, and enforcing regulatory requirements related to various aspects, such as medication records.

North Carolina, for instance, was an early adopter of an Assisted Living Quality Report Card. In 2009, the state introduced a star rating program aimed at assisting consumers in selecting suitable AL communities. This rating system relies on the results of annual inspection surveys that evaluate compliance with standards and requirements, encompassing aspects like the physical condition of AL facilities, admission and discharge procedures, resident assessment and service plans, provision of care services, medication administration, special care units for Alzheimer's and related disorders, use of physical restraints and alternatives, and protection of resident rights.

The primary objective of these state programs and regulations is to foster transparency, accountability, and the overall well-being of residents. By enacting these measures, information becomes more accessible to potential residents and their families, helping them make informed decisions when selecting an assisted living community that fits their needs. Moreover, these programs enforce high standards, ensuring that the facilities follow strict guidelines. This not only guarantees the safety and comfort of residents but also the quality of care they receive. In essence, these efforts are designed to make it easier for individuals and their families to find a high-quality assisted living community that best meets their unique needs and preferences.

- **Maryland:** Center for Quality Measurement and Reporting, Maryland Health Care Commission provides meaningful information to consumers about the quality and performance of hospitals, long-term care facilities and surgical centers. The Oversight Committee on Quality Care in Nursing Homes and Assisted Living Facilities evaluates the quality of assisted-living facility care statewide and the need for the assisted living regulations to be available for public comment.
- **Minnesota:** Resident Quality of Care and Outcomes Task Force was created in 2021 to establish person-centered planning, service delivery, and optimal quality of life requirements for licensure.
- **North Carolina:** North Carolina Star Rated Certificate program is a public reporting Star Rated Certificate program established in response to requests of North Carolina citizens for increased availability of public information regarding the care provided in adult care facilities. The Star Rating program provides consumers with information based on program inspections.

- **New Jersey:** The Advanced Standing for Assisted Living Facilities, conferred by the Health Care Association of New Jersey Foundation (HCANJF), is bestowed to AL Programs who meet regulatory and quality benchmarks for certain quality indicators. This information is publicly available for consumers.
- **Ohio:** Ohio's 2022 Residential Care Facility Family Satisfaction Survey provides overall program satisfaction scores and individual program reports.
- **Oregon:** Oregon's law requires the state to develop a system to measure the quality of care in assisted living facilities (ALFs) and residential care facilities (RCFs) and requires mandatory participation of ALFs in their Residential Care Quality Measurement Program (RCQMP).
- **Washington:** Engrossed House Bill 2750 requires that the Washington State Department of Social and Health Services (DSHS) facilitate a work group process to recommend quality metrics for ALFs.
- **Wisconsin:** Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) is dedicated to improving AL community resident outcomes and has developed an AL Community Scorecard and resident/family satisfaction survey.

These states and the studies they have conducted, however, do not distinguish or breakout AL programs by size to look at any of the above outcomes. Thus, there is some concern about application of their conclusions, methodologies, and implementation processes as they may not be feasible for small AL programs.

Ohio developed and implemented "Resident Care Facility Satisfaction surveys" in 2005.[6] Results from these surveys (along with some indicators regarding type of licensure, etc.) are used for AL rankings across the state and published on a public website. Ohio is one of the states who has both resident and family focused satisfaction surveys based on research studies of quality-of-life measures and domains that span the structure, process, and outcomes domains. Ohio's satisfaction survey is focused on quality-of-life domains such as program culture, program environment, meals and dining and general satisfaction. The state of Oregon has been working to implement their quality measures for RC/AL communities for the last few years. The Oregon legislature mandated the creation of a

[6] Straker, J.K., Mcgrew, K., Dibert, J., Burch, C., & Raymore A. (2016) Ohio's Nursing Home and Residential Care Facility Satisfaction: Survey Testing and Development for Residents and Families. Retrieved from: https://sc.lib.miamioh.edu/xmlui/bitstream/handle/2374.MIA/5925/Ohio%27s%20Nursing%20Homes%20and%20Residential%20Care%20Family%20Satisfaction.pdf

council that will direct implementation of an AL report card and "establish a uniform system for AL communities to report the quality metrics".

In New Jersey, the Health Care Association of New Jersey Foundation (HCANJF) has a distinction bestowed upon AL programs that successfully comply with all state, federal, and local regulations that pertain to licensed assisted living facilities and comprehensive personal care homes in the state of New Jersey.[7] Facilities prove their dedication to quality by meeting benchmarks for certain prescribed quality indicators as chosen by the Peer Review Panel of the HCANJF.

The implementation of quality improvement (QI) programs and regulations is often lacking in many states. However, Wisconsin stands out for its innovative approach led by the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL). Participating AL communities in this program assess their QI structure, processes, and outcomes by regularly self-reporting data at the community level and conducting surveys on resident satisfaction. Feedback reports are generated, comparing data among participating communities, and guiding targeted support from sponsoring organizations to enhance their QI efforts.

B. Improving Maryland's AL Programs: The Need for Comprehensive Data Collection and Quality Benchmarking

In Maryland, there currently exists a significant gap in the quality improvement, benchmarking, and comprehensive data collection strategy for AL programs. This absence creates a barrier to evidence-based decision-making, hindering the ability of healthcare providers, policymakers, and consumers to make informed choices. Timely, reliable, and transparent data is not just a theoretical advantage; it is a practical necessity that empowers residents and their families to select the best care facilities. It enables care providers to continually improve their services by comparing their performance against established benchmarks. Most importantly, a robust data collection framework facilitates governmental oversight, ensuring that AL programs adhere to the highest standards of care. Without this data, the state is operating without complete information, unable to target interventions where they are most needed or measure the impact of those interventions.

[7] Health Care Association of New Jersey. (2023) Advanced Standing for Assisted Living Facilities. Retrieved from: https://www.hcanj.org/consumers/advanced-standing-for-assisted-living-facilities/

Investing in a comprehensive data collection and quality improvement strategy is not merely an expenditure; it is an investment in the health, dignity, and well-being of Maryland's aging population. The establishment of such a system would represent a significant step towards a more transparent, accountable, and effective healthcare landscape, promoting not just the welfare of individual residents but the integrity of the healthcare system.

IV. Comprehensive Review and Analysis of AL Programs in Maryland

Various data sources were analyzed to evaluate the current state of AL programs in Maryland. Appendix C details the methods and results of these analyses. The results are summarized here.

A. Distribution of AL Programs

AL programs are available throughout the state of Maryland, but small programs are disproportionately available. Most programs, regardless of size, are located in the center of the state, leaving the Western, Southern, and Eastern regions with fewer options (Figures 1 and 2). Somerset and Garrett Counties do not have any small AL programs while Baltimore City, Prince George's County, and Baltimore County have 830 small AL programs.

Figure 1. Total Number of AL Programs and Programs with <10 Beds in the Central Region of Maryland

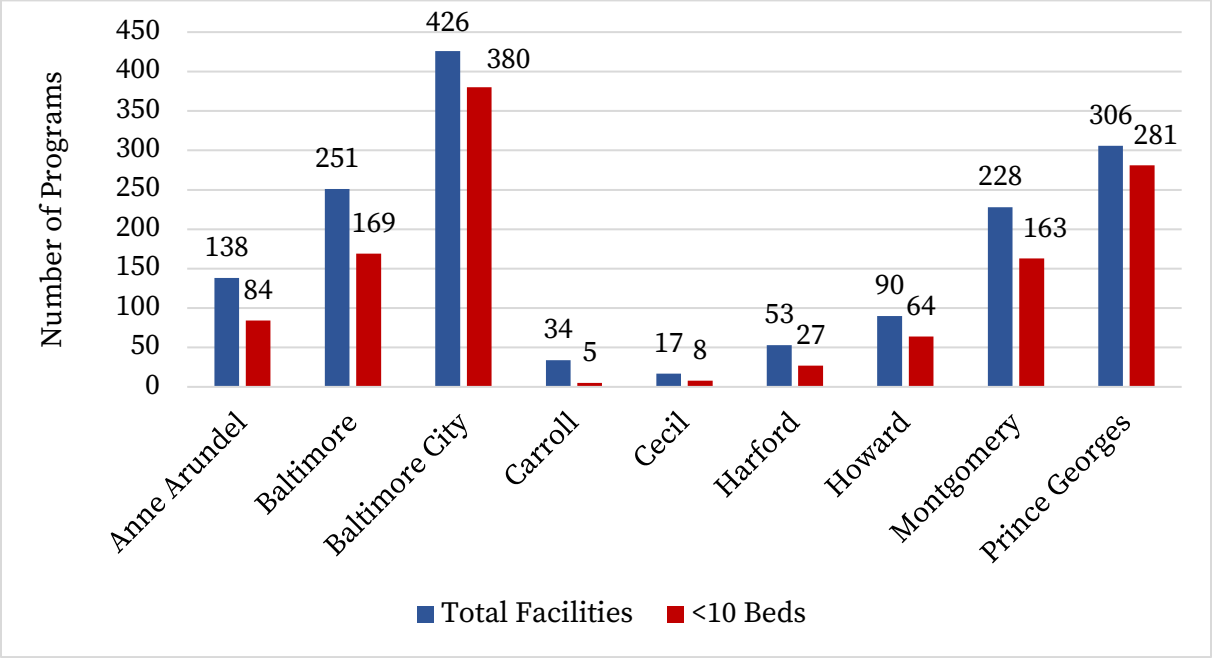
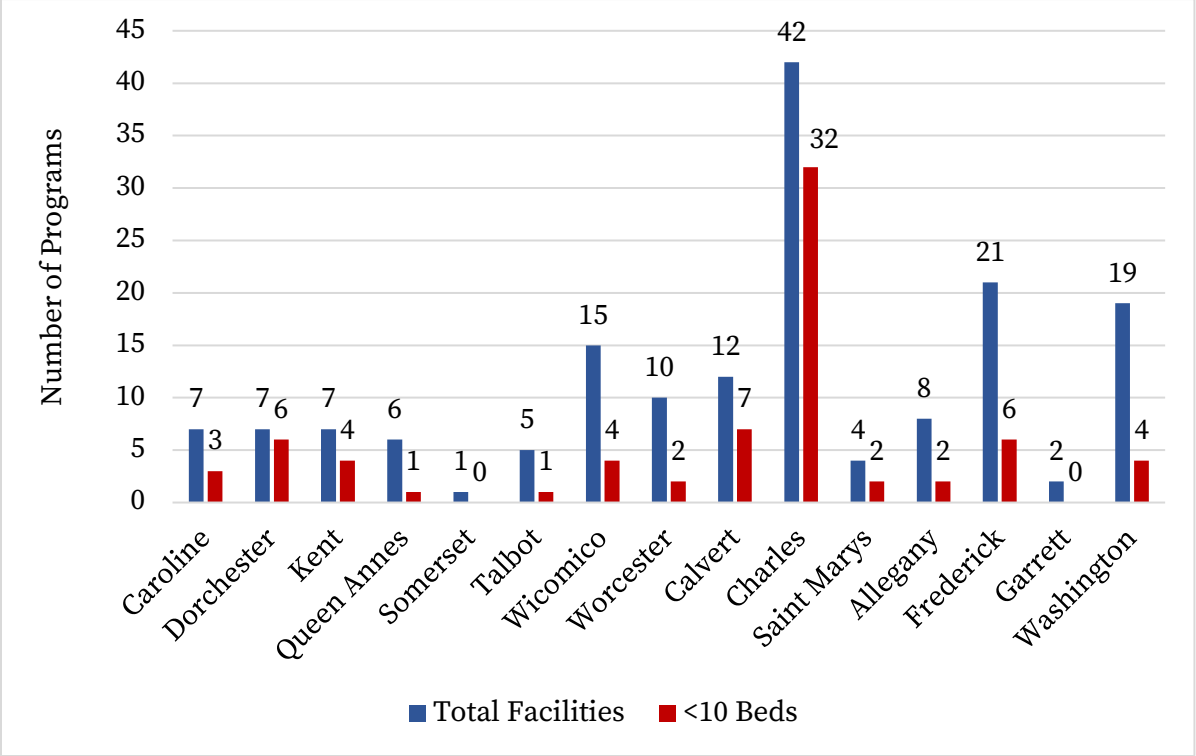


Figure 2. Total Number of AL Programs and Programs with <10 Beds in the Eastern, Western, and Southern Regions of Maryland



The percentage of AL programs with fewer than 10 beds varies widely by region. Most AL programs have <10 beds in the Central (76.5%) and Southern (70.7%) Regions (Table 2). In the Western region, 24.0% of AL programs are considered "small" (24.0%), and in the Eastern region, only 36.2% are considered "small" (Table 2).

Table 2. Percent of Programs with <10 Beds by County and Region

Central	**76.5%**	**Eastern**	**36.2%**	**Western**	**24.0%**	**Southern**	**70.7%**
Anne Arundel	76.5%	Caroline	42.9%	Allegany	25.0%	Calvert	58.3%
Baltimore	60.9%	Dorchester	85.7%	Frederick	28.6%	Charles	76.2%
Baltimore City	67.3%	Kent	57.1%	Garrett	0.0%	St. Mary's	50.0%
Carroll	89.2%	Queen Anne's	16.7%	Washington	21.1%		
Cecil	14.7%	Somerset	0.0%				
Harford	47.1%	Talbot	20.0%				
Howard	50.9%	Wicomico	26.7%				
Montgomery	71.1%	Worcester	20.0%				
Prince George's	91.8%						

Data Source: Assisted Living Deficiency Reports and Census Quarterly Extract

B. Deficiencies Analysis (Study Question A)

The only data available for analysis was 2019-2022. The Workgroup decided not to use 2020 because it would have been significantly impacted by the COVID-19 pandemic, and 2022 data were not complete. Therefore, the data analyzed were 2019 and 2021 data. An in-depth analysis of the deficiencies data revealed that there were 155 deficiencies by complaint with 32 unique programs (2.5%) accounting for all deficiencies. There were 2,786 deficiencies by survey with 385 different AL programs (30.3%) accounting for all deficiencies. The greatest number of deficiencies were in the following three categories: Other Staff Qualifications, Emergency Preparedness, and Medication Management. Please see the OHCQ website to view the definitions of these deficiencies. The data available did not allow us to determine

whether the surveys were initial or renewal surveys, the number of program openings and closings, the total number of complaints reported and investigated, or the patterns of deficiencies over time.

OHCQ conducted an analysis of FY2020 data, and a summary of the FY2020 data can be found on page 16, Table 8 of OHCQ FY21 Annual Report found on the OHCQ website.

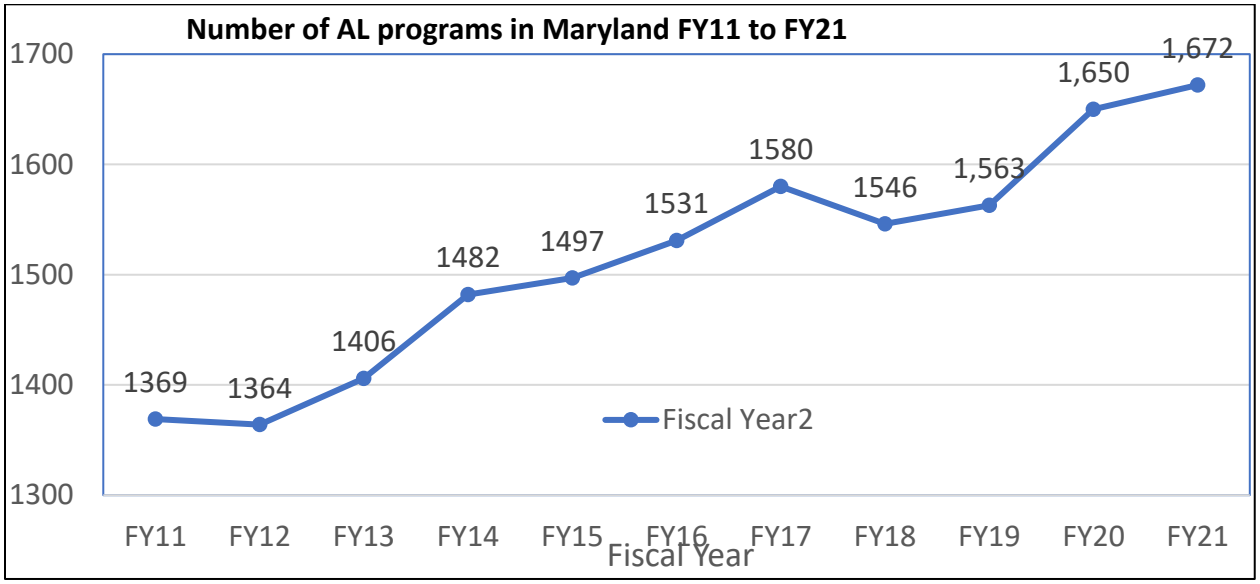
C. Entry and Exit of AL Programs to the Market (Study Question B)

According to the OHCQ, there has been a significant increase in the total number of AL programs from fiscal year 2011 to fiscal year 2021. The number of programs rose from 1,369 in FY2011 to 1,672 in FY2021, indicating a notable growth in the availability of assisted living services. This expansion suggests a growing demand for assisted living options and highlights the importance of providing adequate oversight and regulation to ensure the quality and safety of these programs as they continue to expand.

As part of the continued commitment to oversight and regulation to ensure the quality and safety of AL programs, the following Figure 3 presents the number of AL programs in Maryland from fiscal year 2011 to fiscal year 2021, reflecting the expansion and development of these programs over the decade. Data reflecting the number of programs by size was not available.

Over the fiscal years 2011 to 2021, there were fluctuations in the opening and closure of AL programs. The number of program openings varied annually, with figures ranging from 109 to 218. In terms of closures, the numbers also varied, with figures ranging from 33 to 252. These figures illustrate the dynamic nature of the assisted living industry, with programs opening and closing throughout the years.

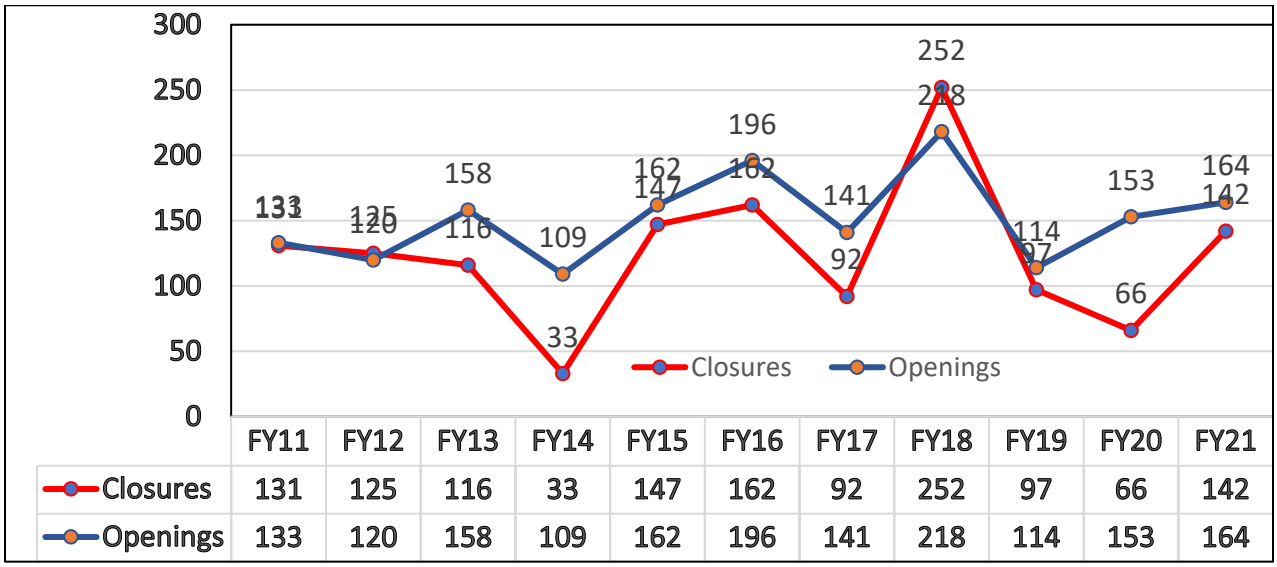
Figure 3. Number of AL Programs in Maryland Fiscal Year 2011 to Fiscal Year 2021



Data source: OHCQ Slide. Licensee Directory: AL programs

Figure 4 provides an overview of the opening and closures of AL programs in Maryland from Fiscal Year 2011 to Fiscal Year 2021, reflecting the dynamic nature of the state's assisted living landscape. Data reflecting the number of programs by size that opened and closed was not available.

Figure 4. Openings and Closures of AL Programs in Maryland Fiscal Year 2011 to Fiscal Year 2021



	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21
Closures	131	125	116	33	147	162	92	252	97	66	142
Openings	133	120	158	109	162	196	141	218	114	153	164

Data source: OHCQ Slide. Licensee Directory: AL programs (2021)

D. MHCC Assisted Living Program Provider Survey 2022-2023

The Assisted Living Provider Survey was conducted among providers listed in the OHCQ distribution list, with an invitation extended to all programs in late 2022. The survey was distributed on three occasions from December 12, 2022, to January 16, 2023. Out of a total of 1,504 recipients, 232 individuals responded, representing a response rate of approximately 15.4%. Overall, the data indicates a mix of new, growing, stable, and long-standing small AL programs. This diversity reflects the dynamic nature of the industry and provides options for individuals seeking care in smaller settings.

The respondents highlighted several key challenges faced by AL programs, both small and large. These barriers can be categorized as Financial and Economic Challenges, Staffing and Training Issues, Quality of Care and Service Provision, Regulatory and Compliance Barriers. Furthermore, respondents suggested several avenues to help them succeed.

1. **Regulatory Guidance:** Out of the survey respondents, 22 pinpointed a significant need for the State of Maryland to furnish clearer regulatory guidance. This reflects a desire for transparent, unambiguous regulations to enhance compliance and elevate the overall quality of care.
2. **Infection Prevention and Control:** 39 respondents emphasized the importance of resources and support for infection prevention and control within AL programs. This finding suggests a need for additional assistance, training, and resources to effectively manage and prevent infections in AL programs.
3. **Specialty Training:** 78 respondents expressed a need for specialized training in areas such as dementia care and medication management. This feedback conveys a call for targeted educational initiatives to address specific domains within care provision.
4. **Flexible Reimbursement Options:** 116 respondents advocated for more expansive and flexible reimbursement options. This suggestion illustrates the need for more flexibility and increased financial support to ensure sustainable operations and improved service quality for AL programs.
5. **General Health Care Training:** With 120 respondents emphasizing the importance of affordable or low-cost general health care training for staff, this points to an essential requirement for accessible education to enhance the skills and knowledge of assisted living program staff members.

6. **Employment Incentives:** A total of 126 respondents recommended the provision of employment incentives to attract and retain competent staff. This suggestion reflects the critical nature of workforce challenges in the industry and the potential impact of providing measures such as competitive salaries, benefits, and career development opportunities.
7. **Increased Reimbursement:** A substantial number of respondents (131) advocated for an increase in the level of reimbursement for assisted living program services. This request indicates a necessity for increased funding to sufficiently meet the financial requirements associated with delivering quality care and services.
8. **Additional Survey Insights:** Additional suggestions encompassed a broad range of needs and potential solutions, including support with resident recruitment; guidance on grants and funding opportunities; provision of regulatory and reimbursement training; facilitating affordable healthcare for staff; streamlining regulations tailored to smaller facilities; and addressing particular concerns such as resident activities, integration with pharmacy software, reimbursement procedures for hospitalizations, regulation of referral agencies, and offering business training for newly established providers.

Cost is a central concern for all AL programs, encompassing various aspects such as facility maintenance, staff wages and retention, staff training, provision of quality services and goods (including food, activities, and supplies), and adequate reimbursement for services. The challenges faced by these programs include difficulties in recruiting and retaining skilled staff members, leading to a pronounced desire for assistance in both staffing and resident acquisition. Beyond the need for financial backing, the respondents express a requirement for guidance and specialized training to adeptly navigate the regulatory landscape, including areas such as specific job training and infection prevention protocols.

Respondents' suggestions underscore the necessity for multifaceted support in Maryland's AL programs. Collectively, the feedback points to an overarching need for robust support, integrating financial aid, information dissemination, and education to address the comprehensive, cost-related challenges facing AL programs. Such an approach would contribute to a marked improvement in the quality of care and the services they deliver.

V. Assisted Living Program Reimbursement and Waiver Programs

A. Assisted Living Program Costs and Trends in Maryland (Study Question E)

AL programs in Maryland, with their varying sizes and care levels, represent a broad spectrum of residential options and associated costs. These programs can range from small individual residences to expansive facilities housing over 100 living units. Understanding the importance of quality and Medicaid reimbursement for AL programs is crucial. The population of individuals aged 60 and above is experiencing significant growth, with Carroll, Cecil, Charles, Frederick, Howard, and St. Mary's counties projected to have the highest percentage increases in this age group.[8]

In 2018, the monthly median cost for AL programs in Maryland was $4,673, surpassing the national average of $4,000. According to Genworth's 2018 Cost of Care Survey, Maryland's assisted living expenses were generally lower than the median costs in neighboring states, except for Pennsylvania and West Virginia. However, significant variations were found within the state itself. While some areas like Cumberland were priced below the national average at less than $4,000 per month, other areas of Anne Arundel County reached a monthly cost of $5,900.

The cost landscape changed further by 2021, where monthly fees for assisted living began to vary based on the specific services provided. The fees typically ranged from $1,000 to $5,000 per month, averaging $4,500, or an annual cost of $54,000. Nationwide comparisons saw monthly rates as low as $3,000 in Missouri to as high as $6,978 in the District of Columbia.

The 2022 Genworth Cost of Care Survey corroborated the rising trend in costs, highlighting an increase in assisted living expenses in recent years. A comprehensive summary of community and assisted living costs in Maryland for the year 2021 is encapsulated in Table 3, offering valuable insights into the financial dynamics of AL programs within the state.

[8] Department of Aging. State Plan on Aging. 2022-2025. Retrieved from: https://aging.maryland.gov/Pages/StatePlanonAging.aspx

Table 3. Community and Assisted Living Costs in Maryland (2021)

MARYLAND	Community and Assisted Living	
	Private, one bedroom	5-Year Annual Growth
Annual Median	$58,800.00	6%
Monthly Median	$5,865.00	-
Daily Median	$161.00	-
Hourly Median	$27.00 (Aide)	-

Data source: 2022 Genworth Cost of Care Survey

B. Alzheimer's and Other Dementia-Related Conditions Reimbursement Under Medicaid or Other State or Local Initiatives

The demand for memory care in Maryland is on the rise. As of 2020, an estimated 110,000 individuals in the state were diagnosed with Alzheimer's disease.[9] Projections indicate that this number could surpass 130,000 by 2025. Memory care costs more than other types of residential care because of the specialized training and resources required to provide high-quality care.[10] With a 20-30% premium over standard assisted living, Maryland's average memory care expense is $6,560 monthly, based on the 2021 Genworth Cost of Care Survey.[11]

Maryland expenses are $1,000 higher than the U.S. average. The cost is lower in Maryland compared to neighboring Washington, D.C. ($7,435 per month) and Delaware ($7,494 per month) but costlier than neighboring Pennsylvania's ($5,125 per month). [12]

C. Adequacy of Payment (Study Question E)

Maryland Medicaid does not directly cover memory care but offers home and community-based services programs for support and cost relief. The Community First Choice program allows qualified individuals to receive long term services and supports (LTSS) in their homes and communities. The Community Options Waiver caters to individuals 18 and older who are aged and/or physically disabled to receive LTSS, preferring care in their private homes or an assisted living setting. Application processes involve the Maryland

[9] Memory Care. (2023) Memory Care in Maryland. Retrieved from: https://www.memorycare.com/memory-care-in-maryland/
[10] Genworth (2022). Cost of Care. Retrieved from: https://www.genworth.com/aging-and-you/finances/cost-of-care.html
[11] Genworth (2022). Cost of Care. Retrieved from: https://www.genworth.com/aging-and-you/finances/cost-of-care.html
[12] Genworth (2022). Cost of Care. Retrieved from: https://www.genworth.com/aging-and-you/finances/cost-of-care.html

Access Point or local Area Agencies on Aging. Eligibility for these programs depends on specific financial, medical, and technical criteria. Medicaid pays five distinct rates for AL services. Effective July 1, 2023 (FY 2024) the rates are as follows: Level II without medical daycare (MDC) is $81.57 per day; Level III without MDC is $102.94 per day; Level II with MDC is $61.21 per day; Level III with MDC is $77.18 per day; Respite in assisted living is $102.94 per day. There will be an 8 percent rate increase for the aforementioned rates, effective January 1, 2024 (FY 2024). As noted above in the section detailing the results of the Assisted Living Provider Survey, providers feel strongly that reimbursement levels and choices are not enough.

Recommendations

This study represents a concerted effort to understand and elevate the quality of assisted living care within Maryland, focusing on those programs serving nine or fewer residents (i.e., small AL programs). It incorporates a broad spectrum of perspectives, providing a well-rounded view of the current landscape, and lays the groundwork for action that can ultimately improve our ability to address the social and health care needs of our senior citizens and other vulnerable populations. Much time was spent gathering information from various stakeholders including state agencies, AL providers, industry representatives and consumer advocates. Our current data infrastructure does not enable us to recommend a detailed approach to regulating small AL programs.

Many individuals decide to enter assisted living programs to continue living in a homelike environment, and they aim for the lowest level of care needed while understanding that their needs may change over time. A resident may need to increase the level of care needed but does not necessarily want to leave their assisted living program, and these recommendations were developed with the understanding that preserving continuity of care is desirable to most residents.

It is important to reiterate that the recommendations included in this report are designed to strengthen our current regulatory system by creating a more efficient and effective data infrastructure that supports inter-agency collaboration, effective oversight and monitoring of AL program performance and ensures the availability of timely and accurate information to support consumer decision making when choosing a provider. The recommendations will require resources from the state to establish a well-coordinated approach that includes better use of technology to support data collection and sharing, support for staff training and educational opportunities, clearly defined agency roles and responsibilities to ensure collaboration across programs, and adequate monitoring of AL

provider performance to protect the health and safety of AL residents. As directed by the legislation, the following recommendations target small AL programs with 2 to 5 beds in the first year, and in the second year, the state shall extend the focus to small AL programs with 1 to 9 beds if the current definition of small is retained. If the recommendation of defining small AL programs as 2 to 16 beds (i.e., the first recommendation below) is adopted, the focus shall shift accordingly.

MHCC shall oversee the implementation of these recommendations, in collaboration with the Department of Aging, the Long Term Care Ombudsman Program, and the Office of Health Care Quality.

Regulatory Framework

Uniform Definition for Small AL Programs (Study Question D):

- **Action:** Adopt a consistent definition for "small AL programs" across all Maryland agencies. The group suggests defining 16 or fewer beds as “small” and 17 or more beds as “large.” Within the category of small ALP, a residential dwelling with 2-5 unrelated individuals shall be the focus of these recommendations in the first year.
- **Rationale**: This standardization will streamline the identification of resource requirements and target support for providers. Within the currently proposed updates to the assisted living regulations in Maryland, programs with a licensed capacity of 17 or more beds are subject to a comprehensive set of requirements. These include provisions for private telephone access in resident rooms, physical site plan reviews, food service permits, assist rails, public restrooms, compliance with food service facility regulations, specific room arrangements, and temperature control measures. These nuanced requirements recognize the diverse operational demands across various AL programs. Facilities with fewer than 17 beds are exempt from these specific regulations, reflecting the state's targeted approach to ensure that regulations are calibrated to the size and complexity of the facility.
- **Timeline:** An agreed upon definition shall be reached by December 1, 2025.

Needs Assessment for Access to AL Programs: (Study Questions B and D)

- **Action:** The Maryland Health Care Commission, in collaboration with the Department of Aging and the Long Term Care Ombudsman Program, will initiate periodic comprehensive needs assessments to identify availability of AL programs by jurisdictions concerning the entry and exit of AL programs in the state. As part of

this action, data sources from the Department of Health, essential for the assessments, will be identified and compiled. A standardized timeline for recurring assessments will be established, specifying whether it will be conducted annually or at a different interval. A detailed resource plan, accounting for manpower, financial, and technological resources, will be designed to sustain the assessment process in the long term.

- **Rationale:** A structured and recurring needs assessment allows for the identification of gaps in Assisted Living Program service availability and will aid in the optimization of resource allocation. This ensures that residents across jurisdictions have equitable access to assisted living services, improving the quality of care and standard of living for Maryland's aging population.
- **Timeline:** Identification of Data Sources by October 1, 2024. Establishment of Recurrence Schedule and Resource Plan by January 1, 2025. Initial Needs Assessment completed by December 31, 2025. First Recurrent Assessment by December 31, 2026, with subsequent assessments to follow the established schedule.

Staff Training Support (Study Question F)

Recruitment, Retention and Training:

- **Action:** To create a larger workforce, the Maryland Department of Labor shall be consulted to support, establish, and facilitate employment and training programs that encourage recruitment, retention, and competency for AL programs. The number of individuals enrolled in training programs should be tracked, retention rates and the percentage of employees meeting competency standards monitored. The state should encourage the development of programs in regions where there is a significant shortage of staff and regions where there are significant numbers of AL programs.
- **Action:** To create a larger workforce, the Department of Labor shall partner with local community colleges to develop training programs and courses that will encourage the development of a well-trained workforce. The state will focus on the development of community college programs in regions where there is a significant shortage of staff and regions where there are significant numbers of AL programs.
- **Rationale:** The overall goal is to create a larger workforce for AL programs. A well-trained, competent, and stable workforce is crucial for maintaining high-quality care and ensuring the well-being of residents in AL programs. By enhancing recruitment and retention efforts and prioritizing continuous employee

development, the Maryland Department of Labor aims to uphold the standards of care, improve resident satisfaction, and minimize turnover-associated costs. The development of coursework and training programs within community colleges will ensure a location to train a competent workforce.

- **Timeline:** Within the next 12 months, the Maryland Department of Labor will roll out targeted employment and training initiatives to boost recruitment, improve retention by at least 10%, and verify the competency of assisted living program employees.

Assisted Living Program Manager Training:

- **Action:** The appropriate state agencies shall review and determine necessary changes to the current comprehensive assisted living program manager training programs to ensure their full compliance with the provisions of Health General §19-1807 and any subsequent legislation enacted in related to the regulation.
- **Rationale:** Assisted living program managers play a pivotal role in setting standards and ensuring compliance within their programs. By equipping them with the latest knowledge and updates from current legislation, it ensures that the entire program operates within the legal framework, guaranteeing residents receive care that meets the highest legal and ethical benchmarks.
- **Timeline:** The specialized training for managers will be rolled out within the next 4 months, with a completion target by July 1, 2025. Ongoing updates and refresher courses will be conducted annually, or whenever new legislation is introduced.

Changing Level of Care:

- **Action:** The appropriate state agencies shall support training programs to help assisted living programs attain the training needed to offer and maintain a higher level of care.
- **Rationale:** Assisted living programs can obtain a license at a lower level of care and later apply for a license to provide a higher level of care. This transition to a higher level of care requires additional training. By assisting programs with attaining the training they need, the State not only encourages a higher level of quality of care, but the State also helps residents stay in their current assisted living program (i.e., continuity of care).

- **Timeline:** Within the next 12 months, the Maryland Department of Labor and the Maryland Department of Health will roll out targeted training assistance for AL programs, changing their level of care.

Reimbursement Policies Assessment (Study Question E)

Reimbursement of the Home and Community Based Waivers Program

- **Action:** Maryland's Medicaid Program shall conduct a thorough reassessment of reimbursement policies in the Maryland Medicaid Home and Community Based Waivers Program.
- **Rationale:** Regularly reassessing Maryland's Medicaid reimbursement policies ensures that the program remains financially sustainable, provides fair compensation to providers, optimizes patient outcomes, keeps pace with medical advancements, and incorporates stakeholder feedback to enhance patient access and reduce potential fraud.
- **Timeline:** Establish a workgroup and a presentation of findings within 3 years.

Reimbursement Policies

- **Action:** In consultation with Medicaid, MHCC shall study ways in which family members can be supported when caring for family with AL program-level needs.[13]
- **Rationale:** AL programs have played an important role in addressing the needs of our older population. The demand for the type of services provided by AL programs will increase as our population continues to age.
- **Timeline**: Build into the FY2027 budget.

Technology and Data Infrastructure Improvement

Data Infrastructure and Inter-Agency Collaboration (Study Questions A and C)

Enhancing OHCQ's Data Infrastructure

- **Action:** The state shall allocate requisite resources to OHCQ to establish and maintain a robust data infrastructure (i.e., inspection/deficiencies results, correction plans, residential agreements, assessments), ensuring timely, efficient, and accurate data collection. Data collected should be publicly available.

[13] This recommendation excludes reimbursement for the costs of room and board.

- **Rationale:** An upgraded infrastructure will expedite data collection processes, guaranteeing accuracy and aiding in real-time decision-making for programs, the state, and the public.
- **Timeline:** Complete infrastructure development and testing within the next 12 months.

Data Collaboration and Information Exchange

- **Action:** MHCC, OHCQ, and other state agencies, shall formalize inter-agency data-sharing arrangements to support timely and accurate data for quality improvement, consumer decision-making, and program performance monitoring.
- **Rationale:** Seamless inter-agency collaboration ensures continuous quality advancements, supports consumer-centric decisions, and aids in accurate performance evaluation.
- **Timeline:** Aim to finalize and implement protocols within the next year by December 31, 2024.

Digital Platform Development for Assisted Living Programs and Integration with the CRISP Health Data Utility

- **Action:** MHCC shall explore the feasibility of funding options and technical requirements to develop a digital platform through the state designated Health Information Exchange (HIE) to facilitate efficient information exchange and data collection and sharing related to AL programs. The platform will include functionality to collect data during a public health or catastrophic emergency. The requirement shall be staged starting with facilities with over 16 beds connecting by January 1, 2026. Facilities with 6 to 16 beds connecting by January 1, 2027, and facilities with 5 beds or fewer establishing connectivity to CRISP by January 1, 2028. All facilities must maintain an active email address and stable internet connections by those respective dates.
- **Rationale:** Leveraging technology for data collection and sharing enhances transparency, accessibility, and efficiency. An online platform will not only modernize the data management process but also ensure stakeholders, including potential residents and their families, have up-to-date information on Assisted Living Program options.
- **Timeline:** Formation of HIE Connectivity Task Force: By July 31, 2024. Design & Development of Online Platform: From October 31, 2025, to December 31, 2025. Beta

Testing and Feedback Collection: From January 31, 2026, to March 31, 2026. Official Launch of Platform: By January 1, 2027, with ongoing updates and maintenance as required.

Committee and Campaign for AL Programs in Maryland

- **Action:** Formulate a joint committee consisting of representatives from relevant state departments and the assisted living industry. The committee will oversee the design and rollout of a public education campaign that illuminates assisted living as a viable long-term care option, detailing its benefits, costs, and the types of care and services offered. The work of the committee shall align with the governor's new Longevity-Ready Maryland Initiative to ensure a well-coordinated and effective statewide campaign. Other long term care programs and services can be incorporated in this public awareness campaign as appropriate.
- **Rationale:** The broader public may be unaware or misinformed about the benefits and functionalities of assisted living as a long-term care solution. A well-structured public education campaign can demystify misconceptions, provide clarity, and potentially ease the transition for families and individuals considering this care option.
- **Timeline:** Formation of Joint Committee: By July 31, 2024. Development and Design of Campaign: From October 31, 2025 to December 31, 2025. Launch of the Campaign: By September 30, 2026, with continued efforts and updates for the subsequent years up to 2029.

State Budget Impact

The financial impact these recommendations place on the state has not been developed at the time. More work is needed to adequately assess the various components of the recommendations.

Appendix A. Text of House Bill 636/Senate Bill 531

HOUSE BILL 636

J3 2lr1434
CF SB 531

By: **Delegate Belcastro**
Introduced and read first time: January 31, 2022
Assigned to: Health and Government Operations

Committee Report: Favorable
House action: Adopted
Read second time: March 2, 2022

CHAPTER _____

AN ACT concerning

Maryland Health Care Commission – Assisted Living Programs – Study

FOR the purpose of requiring the Maryland Health Care Commission, in consultation with the Office of Health Care Quality, the Maryland Long–Term Care Ombudsman Program, the Medicaid Administration, the Governor's Workforce Development Board, and interested stakeholders, to conduct a study regarding the quality of care provided by certain assisted living programs; and generally relating to a study of assisted living programs.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) The Maryland Health Care Commission, in consultation with the Office of Health Care Quality, the Maryland Long–Term Care Ombudsman Program, the Medicaid Administration, the Governor's Workforce Development Board, and interested stakeholders, shall conduct a study regarding the quality of care provided by assisted living programs with nine or fewer beds.

(b) In conducting the study required under subsection (a) of this section, the Commission shall:

(1) analyze the inspection data from the Office of Health Care Quality to determine, on a systemic level, where quality of care may be improved;

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

(2) examine the entry into and exit from the market for assisted living programs, including any noticeable trends related to inspection data or regulatory requirements;

(3) consider the feasibility of developing a reporting system for assisted living programs that protects patient confidentiality and makes data related to catastrophic health emergencies declared by the Governor and quality of care publicly available;

(4) review the current assisted living program licensure regulations to determine whether these programs should be regulated differently than programs with ten or more beds;

(5) determine whether:

(i) assisted living programs receive sufficient reimbursement to cover the cost of care for the services provided, including for residents with Alzheimer's and other dementia–related conditions, under initiatives offered through the Maryland Medicaid Administration or other State or local initiatives; and

(ii) the Home– and Community–Based Options Waiver, or any other waiver program that may be used for assisted living programs, can be revised to improve the quality of care and increase provider participation; and

(6) review staffing resources that could be better utilized and made available for these programs, including measures to encourage the recruitment and retention of staff and meet standards for sufficient staffing.

(c) On or before October 1, 2023, the Maryland Health Care Commission shall report its findings and recommendations, including any draft legislation, to the Governor, the Maryland Department of Health, and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.

Approved:

_____

Governor.

_____

Speaker of the House of Delegates.

_____

President of the Senate.

Appendix B. Workgroup Composition and Meeting Outlines

In October 2022, the Maryland Health Care Commission (MHCC) led the establishment of the Assisted Living Facility Workgroup (Workgroup), a multi-disciplinary workgroup. This Workgroup includes representatives from the following organizations:

1. American Association of Retired Persons
2. Alzheimer's Association, Maryland, and the District of Columbia
3. Governor's Workforce Development Board
4. Health Facilities Association of Maryland/Maryland Center for Assisted Living
5. Leading Age Maryland
6. LifeSpan Representative from Schwartz, Metz, Wise and Kaufman
7. Lorien Harmony Hall
8. Maryland Department of Aging, Office of the State Long-Term Care Ombudsman Program
9. Maryland Department of Health, Office of Health Care Quality
10. Maryland Department of Health, Office of Long Term Services and Supports
11. Maryland Department of Labor, Governor's Workforce Development Board
12. Maryland Health Care Commission
13. Maryland Health Care Commission, Center for Quality Measurement and Reporting
14. Maryland Living Well Center for Excellence
15. Medicaid Administration, Home and Community Based Waiver Program
16. Small Assisted Living Program Representative, Cedar Creek Memory Care Homes
17. Small Assisted Living Program Representative, House of Loving Care

A. Workgroup Members

The composition of this workgroup underscores a commitment to excellence, drawing on representation from subject matter experts and leading organizations in the field of assisted living. Their collective expertise ensures the promotion of the highest standards and best practices throughout Maryland's assisted living sector.

Stacy Howes, Ph.D., Workgroup Chair Chief, Long Term Care Quality Initiatives Center for Quality Measurement and Reporting Maryland Health Care Commission	**Theressa Lee, MPA, CPHQ, Workgroup Vice Chair** Director Center for Quality Measurement and Reporting Maryland Health Care Commission
Ben Steffen Executive Director Maryland Health Care Commission	**Stevanne Ellis** State Long-Term Care Ombudsman Office of the State Long-Term Care Ombudsman Program Maryland Department of Aging
Alexandra Baldi, MPA Operations Director, Administration Unit Office of Health Care Quality Maryland Department of Health	**Carol Fenderson** Deputy Director, State Programs Office of Health Care Quality Maryland Department of Health
Tricia Nay, MD, CHCQM, FAAFP, FABQAURP, FAAHPM Executive Director Office of Health Care Quality Maryland Department of Health	**Courtney Barno** Provider Specialist, Division of Provider Enrollment, Claims, and Compliance Office of Long Term Services and Supports Maryland Department of Health
Lisa Toland, MSFP Chief, Division of Provider Enrollment, Claims, and Compliance Office of Long Term Services and Supports Maryland Department of Health	**Ken Lemberg** Deputy Director Governor's Workforce Development Board Maryland Department of Labor
Tammy Bresnahan Director of Advocacy AARP	**Jim Campbell** AARP State President
Eric Colchamiro Director of Government Affairs Alzheimer's Association Maryland and the District of Columbia	**Joseph DeMattos, MA** President and CEO Health Facilities Association of Maryland
Ruthie Fishman Small Assisted Living Program Representative Cedar Creek Memory Care Homes	**Debbie Gallagher** Executive Director Lorien Harmony Hall
Vanessa Jones Small Assisted Living Program Representative House of Loving Care	**Danna Kauffman** LifeSpan Representative Schwartz, Metz, Wise and Kauffman

B. Meeting Outlines

The agenda items, goals and objectives addressed, and the accompanying materials discussed during the Workgroup meetings are as follows:

Meeting 1 - October 31, 2022

- Agenda
- Meeting Minutes
- Meeting Recording
- Agenda Items #3 and #4 Characterization and Distribution of Current AL Programs and HB 636
- Agenda Item #5 Background on AL Programs
- Agenda Item #6 Draft Survey Questions

Meeting 2 - December 5, 2022

- Agenda
- Meeting Minutes
- Meeting Recording
- Agenda Item # 3 OHCQ Regulatory Overview
- Agenda Item # 4 State Ombudsman Presentation
- Agenda Item # 5 HCBS Overview, Residential Agreement, Reimbursement Overview, Education Manual, EPrep, Reportable Events

Meeting 3 - February 13, 2023

- Agenda
- Meeting Recording
- Agenda Item # 3 Governor's Workforce Development Board: Employment and Wage Data for Assisted Living Related Occupations: Presentation Excel File
- Agenda Item # 4 MHCC Assisted Living Provider Survey Results

Meeting 4 - March 27, 2023

- Agenda
- Meeting Recording
- Agenda Item # 1 HCBW Program HCBW Listing (Excel)
- Agenda Item # 4 Small Assisted Living Provider's Perspective
- Agenda Item # 5 Workgroup Progress Assessment

Meeting 5 - May 22, 2023

- Meeting Recording
- Agenda Item # 1 Study Recommendations (PowerPoint)

- Agenda Item # 2 Workgroup Draft Recommendations

Meeting 6: January 8, 2024

- Agenda
- Meeting Recording
- Agenda Item #1 Study Recommendations (PowerPoint)
- Comments Received

Appendix C. Comprehensive Review and Analysis of AL Programs

In order to review and evaluate the quality of AL programs in Maryland, data were reviewed from the following sources:

- OHCQ provided licensure survey deficiency reports
- OHCQ Reports, Data Summaries, and Presentations
- OHCQ Assisted Living Deficiency Reports and Census Quarterly Extracts provided to MHCC
- Maryland Long-Term Care Ombudsmen Annual Reports
- U.S. Census Data
- United States Postal System, Zip Code Data
- 2022-2023 MHCC Assisted Living Provider Survey
- Maryland Department of Labor, Office of Workforce Information and Performance Reports and Data
- U.S. Department of Labor, Bureau of Labor Statistics Data and Reports
- NCAL Data Summaries

A. Deficiencies Analysis: From the Assisted Living Deficiency Reports and Census Quarterly Extract from OHCQ

SEA Healthcare, a health services research consulting firm, conducted an analysis of the OHCQ Dataset from the Assisted Living Deficiency Reports and Census Quarterly Extract. The data analyzed covered the years 2019 and 2021, excluding 2018 and 2022 due to incomplete data reports. The 2020 data was omitted from the analysis due to the COVID-19 pandemic's impact on OHCQ's survey operations, resulting in a temporary halt in routine inspections and making the collection of inspection data challenging. Despite inspections resuming in early 2021, there may have been lingering impacts on the data from inspections and complaints influenced by pandemic-related factors.

The data for these analyses were classified as either inspection data (e.g., routine or initial surveys) or complaint data. The mechanism for gathering complaint data involved the Long-Term Care Ombudsman, who conveyed information received through calls, emails, in-person visits, and information from other agencies. In contrast, OHCQ collects deficiency data as part of the review of new AL programs seeking licensure in Maryland and during the annual (15 month) survey licensing reviews with existing AL programs. It is

important to recognize that not all complaints or inspections necessarily culminate in a deficiency finding.

Data analyses were largely collected at the jurisdiction level. U.S. Census data and United Staes Postal Office data were used to identify each assisted living program's jurisdiction to be able to conduct the analyses on the jurisdiction level.

According to the guidelines set by the Maryland Department of Health (MDH) (2022) a reportable event refers to an allegation or an actual occurrence of an incident that has a negative impact or the potential to negatively impact the health, welfare, or safety of a participant. It is the responsibility of all individuals working with long-term services and supporting programs[14] to report such events promptly to the participant's Supports Planner, Adult Protective Services, OHCQ, Medicaid Division of Quality and Compliance Review (if applicable), and, when appropriate, to law enforcement.

Based on the data and subsequent analysis, MHCC and SEA Healthcare were able to determine:

- Total programs with nine beds or fewer: 1,272 facilities
- Most frequently cited deficiencies in 2019 and 2021 by tag
- Complaints
    - 155 deficiencies by complaints
    - 32 unique programs (2.5%)
    - 1,240 programs with no deficiencies by complaints
- Surveys
    - 2,786 deficiencies by survey
    - 385 unique programs (30.3%)
    - 887 programs with no deficiencies by survey
- The greatest number of deficiencies across all jurisdictions and reporting periods is:
    - Other Staff Qualifications: 1,216
    - Emergency Preparedness: 1,168
    - Medication Management: 699

The available data did not provide sufficient information to determine:

- Whether the survey was initial or renewal

[14] The Long Term Care Ombudsman program is an exception to this rule. The Ombudsman Program is not a not mandatory reporter program as required by federal law and regulation.

- Number of closures and openings
- Total number of complaints reported and investigated.
- Patterns over time without additional data points

B. Long-Term Care Ombudsman Report Fiscal Year 2021

The Maryland Long-Term Care Ombudsman (LTC Ombudsman) Program is responsible for protecting the rights and promoting the well-being of residents of long-term care programs. The LTC Ombudsman works to resolve problems of individual residents and to bring about changes at the local, state, and national levels that will improve residents' care and quality of life.

In the context of AL programs, a comprehensive review of the resident complaint data revealed a total of 591 complaints documented across various categories. The complaints encompassed a range of areas including care, autonomy, choice, and rights of residents. Issues related to admissions, transfers, discharge, and evictions were also raised. Access to information, financial matters, and personal property concerns were part of the complaints as well. Instances of abuse, gross neglect, and exploitation were reported, highlighting the need for vigilance in resident safety. Other areas of concern included dietary considerations, environmental conditions, facility policies, procedures, and practices. Additionally, complaints highlighted the significance of activities, community integration, and social services, reinforcing the necessity for a holistic and considerate approach to resident experience within AL programs.

C. Assisted Living Program OHCQ Deficiency Data by Jurisdiction

The Analysis Team conducted a thorough assessment of the distribution of deficiencies reported by OHCQ across various programs within each jurisdiction. The examination revealed that most inspection or complaint deficiencies were concentrated within a limited number of unique programs in individual jurisdictions.

A comparison of deficiency data between 2019 and 2021 highlighted an increase in the number of small bed AL programs, growing from 1,190 to 1,272. Conversely, there was a decrease in the total number of complaint deficiencies from 932 to 155, with these stemming from a reduced number of unique programs (declining from 148 to 32). Additionally, the total number of inspection deficiencies also decreased from 5,784 to 2,759, originating from a reduced number of unique small bed AL programs, from 668 to 383.

The underlying cause of the decrease in deficiencies observed between the years 2019 and 2021 is not readily apparent. Various factors may have contributed to this trend, including potential disruptions in the number of completed complaints and inspections. While the ongoing effects and impact of the COVID-19 pandemic could have played a role, the specific correlation remains unclear. The period in question witnessed a marked reduction in the overall number of recorded deficiencies, a phenomenon that warrants further investigation to accurately determine the underlying factors influencing this pattern. Additionally, the Maryland Department of Health experienced a network security incident that greatly impeded the ability to collect and share data.

The following section provides a detailed look at the jurisdictions that recorded the highest number of complaint deficiencies in 2019 and in 2021. By examining the range and concentration of these deficiencies across different regions, a more nuanced understanding is achieved of where and how these deficiencies were concentrated, thus enabling targeted insights into specific areas that may need attention or intervention.

2019 Jurisdictions with the Highest Number of Complaint Deficiencies (Range 0-348)

- Baltimore City (348) complaint deficiencies from 52 Small AL Programs
- Baltimore County (186) complaint deficiencies from 35 Small AL Programs
- Montgomery County (133) complaint deficiencies from 19 Small AL Programs
- Prince Georges County (127) complaint deficiencies from 27 Small AL Programs
- Howard County (76) complaint deficiencies from 8 Small AL Programs
- Anne Arundel County (24) from 5 Small AL Programs

2019 Jurisdictions with the Highest Number of Inspection Deficiencies (Range 0-2,397)

- Baltimore City (2,397) inspection deficiencies from 251 Small AL Programs
- Prince Georges County (1,081) inspection deficiencies from 118 Small AL Programs
- Baltimore County (622) inspection deficiencies from 77 Small AL Programs
- Montgomery County (480) inspection deficiencies from 66 Small AL Programs
- Howard County (400) inspection deficiencies from 46 Small AL Programs

2021 Jurisdictions with the Highest Number of Complaint Deficiencies (Range 0-44)

- Baltimore City (44) complaint deficiencies from 8 Small AL Programs
- Baltimore County (37) complaint deficiencies from 6 Small AL Programs

- Montgomery County (28) complaint deficiencies from 6 Small AL Programs
- Prince Georges County (25) complaint deficiencies from 6 Small AL Programs
- Anne Arundel County (13) complaint deficiencies from 3 Small AL Programs
- St Mary's County (4) complaint deficiencies from 1 Small AL Program

2021 Jurisdictions with the Highest Number of Inspection Deficiencies (Range 0-924)

- Baltimore City (924) inspection deficiencies from 106 Small AL Programs
- Prince Georges County (755) inspection deficiencies from 96 Small AL Programs
- Montgomery County (345) inspection deficiencies from 67 Small AL Programs
- Baltimore County (264) inspection deficiencies from 40 Small AL Programs
- Howard County (157) inspection deficiencies from 25 Small AL Programs
- Anne Arundel County (128) inspection deficiencies from 25 Small AL Programs

The following tables provide a comprehensive overview of the deficiency statistics related to AL programs within various jurisdictions in 2019 and in 2021. This detailed breakdown elucidates the scope and distribution of deficiencies, encompassing both complaints and inspections. It highlights the areas that may necessitate focused examination or intervention, thereby offering a roadmap for potential improvements and regulatory oversight.

Table 4. 2019 Distribution and Analysis of Deficiencies in AL Programs by Jurisdiction

Year	Jurisdiction	Total SB* Program Count	Total Number of Complaint Deficiencies	Number of Unique Programs with Complaints	Number of Programs with No Complaint Deficiencies	Total Number of Inspection Deficiencies	Number of Unique Programs with Inspection Deficiencies	Number of Programs with No Inspection Deficiencies
2019	ALLEGANY	2	0	0	2	0	0	2
2019	ANNE ARUNDEL	74	24	5	69	214	38	36
2019	BALTIMORE	138	186	35	103	622	77	61
2019	BALTIMORE CITY	363	348	52	311	2397	251	112
2019	CALVERT	6	0	0	6	8	1	5
2019	CAROLINE	4	4	1	3	17	3	1
2019	CARROLL	5	2	1	4	13	2	3
2019	CECIL	8	0	0	8	56	5	3
2019	CHARLES	36	0		35	126	21	15
2019	DORCHESTER	5	0	0	5	25	3	2
2019	FREDERICK	6	14	1	5	48	5	1
2019	GARRETT	0	0	0	0	0	0	0
2019	HARFORD	23	16	1	22	181	18	5
2019	HOWARD	59	76	8	51	400	46	13
2019	KENT	5	0	0	5	25	5	0
2019	MONTGOMERY	175	133	19	156	480	66	109
2019	PRINCE GEORGES	267	127	24	243	1081	118	149
2019	QUEEN ANNES	1	0	0	1	0	0	1
2019	SAINT MARYS	5	0	0	5	25	5	0
2019	SOMERSET	0	0	0	0	0	0	0
2019	TALBOT	1	0	0	1	22	1	0
2019	WASHINGTON	4	2	1	3	30	2	2
2019	WICOMICO	2	0	0	2	0	0	2
2019	WORCESTER	1	0	0	1	14	1	0
	TOTAL	1190	932	148	1041	5784	668	522

*SB Program is an AL program with less than 10 beds.

Table 5. 2021 Distribution and Analysis of Deficiencies in AL Programs by Jurisdiction

Year	Jurisdiction	Total SB Program Count	Total Number of Complaint Deficiencies	Number of Unique Programs with Complaints	Number of Programs with No Complaint Deficiencies	Total Number of Inspection Deficiencies	Number of Unique Programs with Inspection Deficiencies	Number of Programs with No Inspection Deficiencies
2021	ALLEGANY	2	0	0	2	0	1	1
2021	ANNE ARUNDEL	83	13	3	80	128	25	58
2021	BALTIMORE	184	37	6	178	264	40	144
2021	BALTIMORE CITY	367	44	8	359	924	106	261
2021	CALVERT	7	0	0	7	9	2	5
2021	CAROLINE	3	0	0	3	0	0	3
2021	CARROLL	5	2	1	4	5	1	4
2021	CECIL	9	0	0	9	12	1	8
2021	CHARLES	38	2	1	37	75	6	32
2021	DORCHESTER	5	0	0	5	6	1	4
2021	FREDERICK	7	0	0	7	2	1	6
2021	GARRETT	0	0	0	0	0	0	0
2021	HARFORD	24	0	0	24	74	10	14
2021	HOWARD	64	0	0	64	157	25	39
2021	KENT	4	0	0	4	0	0	4
2021	MONTGOMERY	176	28	6	170	345	67	109
2021	PRINCE GEORGES	282	25	6	276	755	96	186
2021	QUEEN ANNES	1	0	0	1	0	0	1
2021	SAINT MARYS	2	4	1	1	0	0	2
2021	SOMERSET	0	0	0	0	0	0	0
2021	TALBOT	1	0	0	1	3	1	0
2021	WASHINGTON	4	0	0	4	25	2	2
2021	WICOMICO	3	0	0	2	0	0	2
2021	WORCESTER	1	0	0	1	0	0	1
	TOTAL	1264	155	32	1232	2759	383	881

*SB Program is an AL program with less than 10 beds.

Comparative Analysis of Common Deficiencies: Inspection vs. Complaint (2019-2021). This section presents an in-depth analysis of the most common types of deficiencies found through inspections or complaints, as identified across various jurisdictions in 2019 and 2021. The findings have been organized into two main categories: complaint deficiencies and inspection deficiencies, to offer a detailed understanding of the specific areas that may warrant further examination and intervention.

Inspection Deficiencies:

The top three categories for inspection deficiencies are:

2019 Top Three (3) Inspection Deficiencies Overall

1. Other Staff—Qualifications – 816 occurrences
2. Emergency Preparedness – 733 occurrences
3. Medication Management and Administration – 465 occurrences

2021 Top Three (3) Inspection Deficiencies Overall

1. Emergency Preparedness – 433 occurrences
2. Other Staff Qualifications – 412 occurrences
3. Service Plan – 400 occurrences

Combined 2019 and 2021 Top Three (3) Inspection Deficiencies Overall

1. Other Staff Qualifications – 1,216 occurrences
2. Emergency Preparedness – 1,166 occurrences
3. Medication Management and Administration – 699 occurrences

There was a significant decrease in total inspection deficiencies, from 5,769 in 2019 to 2,786 in 2021. This reduction of nearly 52% may suggest improvements in compliance with regulatory standards, changes in inspection protocols, or the influence of the COVID-19 public health emergency, which potentially led to a decrease in the number of completed inspections. Other underlying factors could also have contributed to this trend. Such a substantial decline emphasizes the importance of continued monitoring and analysis to understand the specific reasons behind this reduction and to ensure that the decrease in deficiencies does not compromise the rigor and effectiveness of the inspection process. This insight may also guide targeted interventions and policy decisions to maintain and enhance the overall quality and safety of the inspected programs.

Complaint Deficiencies:

The top three categories for complaint deficiencies are as follows:

2019 Top Three Complaint Deficiencies Overall Jurisdictions

1. General Physical Plant – 386 citations
2. Other Staff—Qualifications – 290 citations
3. Delegating Nurse – 266 citations

2021 Top Three Complaint Category Deficiencies Overall Jurisdictions

1. Other Staff—Qualifications – 170 citations
2. Other Staff—Qualifications – 147 citations
3. Delegating Nurse – 146 citations

Combined 2019 and 2021 Top Three Complaint Category Deficiencies Overall Jurisdictions

1. General Physical Plant – 524 citations
2. Other Staff Qualifications – 460 citations
3. Delegating Nurse – 412 citations

In the period between 2019 and 2021, there was a significant decrease in total complaint deficiencies within the inspected healthcare facilities. Specifically, the data delineates a marked reduction from 935 deficiencies in 2019 to 155 in 2021. This considerable drop, representing an 83.42% decrease over the two-year span, may have been influenced by various factors, including changes in regulatory enforcement or the effects of the COVID-19 public health emergency.

Through careful contrast and examination of the data across these two years, the analysis unravels critical insights into both inspection and complaint deficiencies. It not only pinpoints the areas requiring sustained focus but also furnishes a comprehensive understanding of the trends and patterns in deficiencies. These findings are instrumental in guiding ongoing efforts to enhance compliance standards and systematically address recurring challenges within the inspected domains, reinforcing the broader objectives of healthcare quality, safety, and patient-centric care.

Inspection Deficiencies Spotlight: A Focus on Recurring Areas in Staff Qualifications, Emergency Preparedness, and Physical Plant Requirements

This analysis highlights the specific areas where deficiencies were frequently identified during inspections, providing valuable insight into areas that require attention and improvement. By addressing these recurring deficiencies related to staff qualifications, emergency preparedness, and physical plant requirements, steps can be taken to enhance the overall quality and compliance of the inspected AL programs.

Tables 6, 7, and 8 delineate the most frequent inspection deficiency state tags, along with prefix code descriptions, for the years 2019, 2021, and the combined data for both years, respectively, highlighting the recurring and emerging trends in inspection deficiencies.

Table 6. 2019 Most Frequent Inspection Deficiency State Tags with Prefix Code Descriptions

State Tag/ Deficiency Prefix Code	Deficiency Description	Count
E2600-.19	Other Staff--Qualifications	208
E4630-.41	General Physical Plant Requirements	206
E4910-.46	Emergency Preparedness	206
E2550-.19	Other Staff--Qualifications	202
E4900-.46	Emergency Preparedness	171

Table 7. 2021 Most Frequent Inspection Deficiency State Tags Prefix Code Descriptions

State Tag/ Deficiency Prefix Code	Deficiency Description	Count
E4900-.46	Emergency Preparedness	123
E4910-.46	Emergency Preparedness	117
E2600-.19	Other Staff--Qualifications	109
E3330-.26	Service Plan	107
E2000-.13	Administration	91

Table 8. 2019 and 2021 Combined Most Frequent Inspection Deficiency State Tags with Prefix Code Descriptions

State Tag/ Deficiency Prefix Code	Deficiency Description	Count
E4910-.46	Emergency Preparedness	323
E2600-.19	Other Staff--Qualifications	317
E4900-.46	Emergency Preparedness	294
E2550-.19	Other Staff--Qualifications	290
E4630-.41	General Physical Plant Requirements	283

Analysis of Trending Complaint Deficiencies: A State Tag and Deficiency Prefix Code Perspective for 2019 and 2021

This analysis focuses on the examination of complaint deficiencies categorized by their State Tags or Deficiency Prefix Codes for the years 2019 and 2021, as well as their combined data. By studying these codes, we gain insight into specific areas where complaints occurred and identify trends in deficiencies over time.

Tables 9 and 10 present the top Prefix Codes/State Tags for deficiencies as identified from OHCQ surveys for the years 2019 and 2021, respectively, offering a detailed view of the specific areas of concern for each year; Table 11 provides a consolidated view of the top Prefix Codes/State Tags for deficiencies, as identified from OHCQ surveys, across the years 2019 and 2021, offering a succinct comparison and insight into the most prevalent areas of concern.

Table 9. 2019 Top Prefix Codes/State Tags for Deficiencies from OHCQ Surveys

State Tag/ Deficiency Prefix Code	Deficiency Description	Count
E4630-.41	General Physical Plant Requirements	52
E3680-.29	Medication Management and Administration	35
E3420-.27	Resident Record or Log	30
E1880-.11	Investigation by Department	27
E2780-.20	Delegating Nurse	25

Table 10. 2021 Top Prefix Codes/State Tags for Deficiencies from OHCQ Surveys

State Tag/ Deficiency Prefix Code	Deficiency Description	Count
E3960-.35	Resident's Rights	19
E3680-.29	Medication Management and Administration	6
E2800-.21	Preadmission Requirements	6
E3790-.31	Incident Reports	5
E4630-.41	General Physical Plant Requirements	4

Table 11. Combined 2019 and 2021 Top Prefix Codes/State Tags for Deficiencies from OHCQ Surveys

State Tag/ Deficiency Prefix Code	Deficiency Description	Count
E4630-.41	General Physical Plant Requirements	56
E3960-.35	Resident's Rights	44
E3680-.29	Medication Management and Administration	41
E3420-.27	Resident Record or Log	34
E1880-.11	Investigation by Department	30

Detailed Descriptions for Top Deficiencies by Prefix Code or State Tag

The deficiencies arising from survey inspections across all jurisdictions and both reporting periods were analyzed and grouped by State Tags or Deficiency Prefix Codes. The most prevalent deficiencies categorized by these parameters were identified as follows:

1. Other Staff Qualifications: 1,216 occurrences
2. Emergency Preparedness: 1,166 occurrences
3. Medication Management: 699 occurrences

Among these, medication management emerges as a particularly significant area of deficiency within all AL programs, and it is especially pronounced in smaller AL programs. The improper handling of medications, encompassing errors in administration and oversight, can have far-reaching consequences on residents' health and overall quality of life. Such deficiencies can lead to adverse drug effects, posing substantial risks and

potentially resulting in serious health complications.[15] The data emphasizes the critical need for meticulous attention to this aspect of care to ensure the safety and well-being of residents.

Final Summary Table of Other Staff Qualifications Deficiencies

A comprehensive review of inspection deficiencies related to Other Staff Qualifications for the years 2019 and 2021 reveals that the predominant issue within this category is associated with the code E2600-.19, pertaining to Initial and Annual Skills Training. This specific deficiency accounted for 319 occurrences within the examined timeframe, reflecting a significant area of concern that merits attention and corrective action.
The following table (13) presents a comprehensive summary of deficiencies related to Other Staff Qualifications for the years 2019 and 2021. This analysis is organized by the State Tag/Prefix Code and delineates the specifics of each deficiency through a brief description, offering detailed counts for both complaints and inspections across the given years. The data includes individual tallies for 2019 and 2021 as well as combined totals for both complaints and inspections, culminating in the grand total of all deficiencies. This summary serves as a valuable resource for understanding the scope, trends, and areas that may require targeted interventions or increased oversight within the domain of staff qualifications across the jurisdictions under review.

[15] Chun, J., Appel, S.J., Simmons, S. (2018) 2015 Beers criteria medication review in assisted living facility J AANP 30(11): 648-654.

Table 12. Deficiencies in Other Staff Qualifications: 2019 & 2021 Analysis by State Tag/Prefix Code

State Tag/ Prefix Code	Deficiency Prefix Code/Type and Brief Description	Complaints 2019	Complaint 2021	Complaint Total 2019 & 2021	Inspection 2019	Inspection 2021	Inspection Total 2019 & 2021	Total for 2019 (Complaints and Inspections)	Total for 2021 (Complaints and Inspections)	Grand Total for All 2019 and 2021 Deficiencies
2540	E2540-.19 Sufficient Number of Staff	3	2	5	3	0	3	6	2	8
2545	E2545-.19 Age Requirements	11	2	13	2	0	2	13	2	15
2550	E2550-.19 Free From Tuberculosis, Measles, Mumps, Rubella, and Varicella	8	1	9	202	88	290	210	89	299
2560	E2560-.19 Criminal History and	2	0	2	91	44	135	93	44	137
2580	E2580-.19 Sufficient Skills, Training, Education, and Experience	14	4	18	7	0	7	21	4	25
2600	E2600-.19 Initial and Annual Training	2	0	2	208	109	317	210	109	319
2620	E2620-.19 Licensure or Certification	12	3	15	8	0	8	110	3	113
2630	E2630-.19 Demonstrated Competence	6	0	6	104	56	160	49	56	105
2640	E2640-.19 Basic CPR Training	4	0	4	45	13	58	49	13	62
2650	E2650-.19 Relief Personnel	1	0	1	1	0	1	2	0	2
2660	E2660-.19 Proof of Training	3	0	3	15	7	22	18	7	25
2670	E2670-.19 Training in Cognitive Impairment and Mental Illness	1	1	2	48	20	68	49	21	70
2710	E2710-.19 Training- Non-Personal Care	3	2	5	2	1	3	5	3	8
2730	E2730-.19 Training and Training Methods	11	2	13	80	62	142	91	64	155
2740	E2740.19 Additional Training for Delegating Nurse	0	0	0	0	0	0	0	0	0
	Grand Total	**81**	**17**	**98**	**816**	**400**	**1216**	**926**	**417**	**1343**

Analysis of Medicaid Waivers in AL Programs: A Focus on Home and Community-Based Services (HCBS) in Maryland

The OHCQ census data specifically focused on small bed AL programs in Maryland, those with nine beds or fewer. This targeted analysis identified whether each of these programs possessed a Medicaid Home and Community-Based Services (HCBS) Waiver.
Out of the small bed AL programs examined, 1,379 were marked with a (1), indicating that they held a Medicaid Waiver. OHCQ provided this information in their quarterly census data, and it was broken down by jurisdiction to show the count of HCBS waivers specifically for these small bed AL programs within the state.

The insights gleaned from this examination are critical in understanding the distribution of Medicaid HCBS Waivers across Maryland, shedding light on areas where these waivers are

most prevalent. Such detailed analysis can be instrumental in guiding state policy, regulation, and quality improvement initiatives related to community-based care within these specific facilities.

Table 13 provides a comprehensive breakdown by jurisdiction, detailing the number of HCBS waivers held by small bed AL programs in both 2019 and 2021. This comparison offers valuable insights into the trends and changes in the distribution of these waivers over the two-year period.

Table 13. Count of Medicaid HCBS Waivers in Small-Bed AL Programs Across Jurisdictions in Maryland: 2019 and 2021 Comparison

Jurisdiction	2019	2021
Baltimore City	116	103
Prince Georges	122	70
Baltimore	62	45
Montgomery	60	32
Anne Arundel	43	17
Howard	33	21
Charles	11	11
Harford	10	5
Frederick	5	2
Cecil	3	4
Calvert	3	1
Carroll	3	2

Jurisdiction	2019	2021
Kent	3	1
Caroline	3	1
Dorchester	1	3
Washington	1	0
Allegany	1	2
Wicomico	1	0
Queen Annes	1	1
Talbot	1	0
Worcester	1	1
St Mary's	0	0
Garrett	0	0
Somerset	0	0

Data Source: Assisted Living Deficiency Reports and Census Quarterly Extract, OHCQ 2022

According to Medicaid, a total of 559 AL programs in Maryland were reported to have Home and Community-Based Services (HCBS) waivers. The records from the Office of Health Care Quality (OHCQ) revealed the number of HCBS waivers specifically for small bed AL programs in Maryland, with 9 or fewer beds, as follows:

- **In 2019:** There were 484 HCBS waivers.
- **In 2021:** There were 322 HCBS waivers.

These numbers represent a noticeable decrease over the two-year period.

Jurisdictions with the Highest Number of Waivers: More small AL programs had an HCBS waiver in 2019 (484 HCBS Waivers) compared to 2021 (322 HCBS Waivers).

The jurisdictions with the highest number of waivers were as follows:

- **2019 HCBS Waivers (count):** Prince Georges (122), Baltimore City (116), Baltimore County (62)
- **2021 HCBS Waivers (count):** Baltimore City (103), Prince George's (70), Baltimore County (45)

This information highlights specific areas with the most prevalent use of HCBS waivers and indicates a shift in the allocation and utilization of these waivers. The decrease in waivers from 2019 to 2021 may be related to underlying changes in policy, regulations, or the needs and preferences of AL programs. Additionally, the reduction in HCBS waivers may also be influenced by challenges and disruptions caused by the COVID-19 pandemic. The pandemic's widespread impacts on healthcare service delivery, regulatory compliance, and facility operations could have played a role in the trends in HCBS waivers. Understanding this precise correlation would necessitate a comprehensive analysis, considering various factors and their interplay during these extraordinary circumstances.

D. MHCC Assisted Living Program Provider Survey

The Assisted Living Provider Survey was conducted among providers listed in the OHCQ distribution list, with an invitation extended to all programs in late 2022. The survey was distributed on three occasions from December 12, 2022, to January 16, 2023. Out of a total of 1,504 recipients, 232 individuals responded, representing a response rate of approximately 15.4%. Overall, the data indicates a mix of new, growing, stable, and long-standing small AL programs. This diversity reflects the dynamic nature of the industry and provides options for individuals seeking care in smaller settings.

Table 14. Survey Respondents by Size of Assisted Living Program

	≥10 Beds	≤9 Beds
Count	132	100
Percent	56.9%	43.1%

	≥16 Beds	7-15 Beds	≤6 Beds
Count	82	59	91
Percent	35.3%	25.4%	39.2%

According to the survey, there was a correlation between the size of AL programs and the number of reported employees. Smaller programs generally indicated a lower count of both full-time and part-time employees.

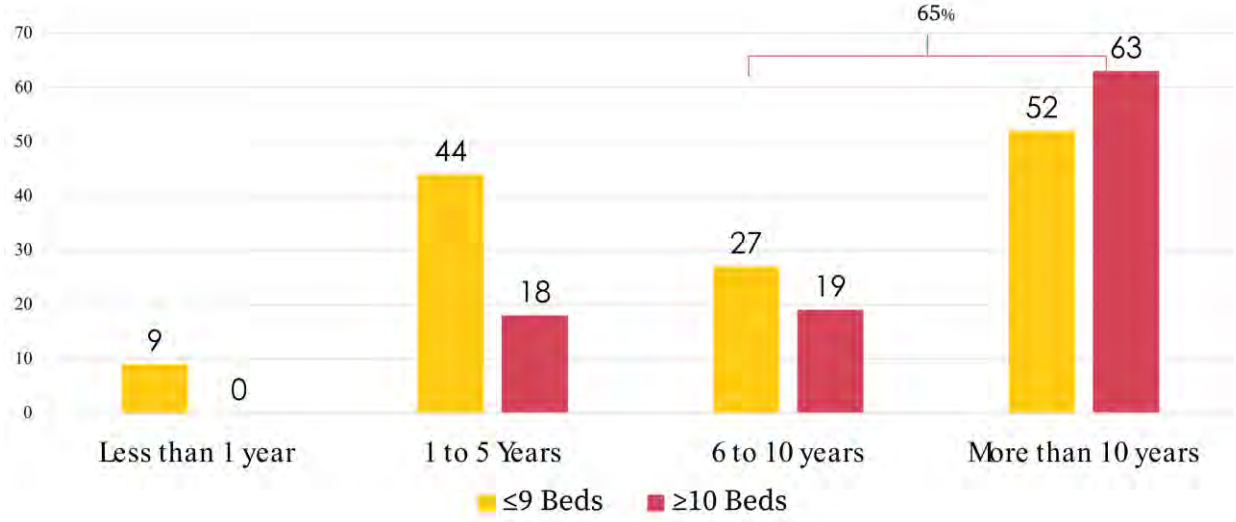
Table 15. Number of Full-Time and Part-Time Employees Reported by Size of Assisted Living Program in Survey

	Full Time			Part Time		
	≤ 6 Residents	7-15 Residents	≥ 16 Residents	≤ 6 Residents	7-15 Residents	≥ 16 Residents
≤10 Employees	110	45	9	110	49	33
11-49 Employees	0	4	46	0	0	34
≥50 Employees	0	0	18	0	0	6

The AL programs exhibited a wide range of operational durations, from under one year to over a decade. Among programs with nine or fewer beds, the distribution was as follows: 9 programs had been operating for less than 1 year, 44 for 1 to 5 years, 27 for 6 to 10 years, and 52 for more than 10 years. Conversely, among programs with 10 or more beds, there were no programs operating for less than 1 year, while 18 had been in operation for 1 to 5 years, 19 for 6 to 10 years, and 63 for more than 10 years.

The diversity in the length of time these AL programs have been operating provides a valuable perspective on the maturity and stability of services. This information sets the context for a further analysis presented in the following table, which focuses on another significant aspect of AL programs.

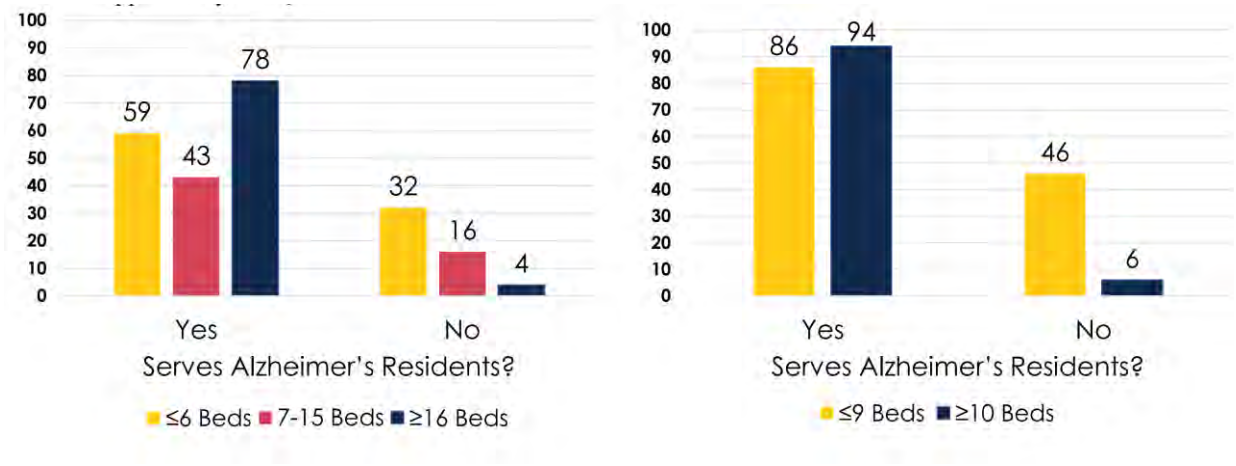
Figure 5. Duration of Operation for AL Programs as Reported by Survey Respondents



Overall, the data indicates a mix of new, growing, stable, and long-standing small AL programs. This diversity reflects the dynamic nature of the industry and provides options for individuals seeking care in smaller settings.

Among the survey respondents, 180, or 77.6%, indicated that their organization offers care to residents with Alzheimer's disease or dementia. Within this subset, 59 respondents, representing 32.8% of those providing such care, stated that they operate an Alzheimer's disease SCU, as outlined in COMR 10.07.14.30 and approved by OHCQ. These numbers reflect the considerable attention that AL programs are giving to Alzheimer's disease and dementia care. Details are further illustrated in Figure 6:

Figure 6. AL Programs that Provide Care to Residents with Alzheimer's Disease or Dementia



The survey respondents identified various barriers to providing quality services in AL programs. A significant number of respondents (65, or 28%) reported no barriers to delivering quality services. However, most respondents stated they encountered barriers, with 107 (46.1%) indicating one or two barriers, and 60 (25.9%) facing three or more barriers.

Table 16. Distribution of Barriers to Providing Quality Services as Reported by Respondents

Do you experience barriers to providing quality services?	≤9 Beds	≥10 Beds
No. We don't experience barriers.	36	29
Yes, 1 or 2 barriers.	60	47
Yes, 3+ barriers	36	24

Identified Barriers in AL Programs

The respondents have highlighted several key challenges faced by AL programs, both small and large. These barriers can be categorized as follows:

1. **Financial and Economic Challenges:**
    - High inflation and/or supply chain problems (133 respondents)

- Lack of staffing (130)
- Lack of funds to attract and retain highly trained and educated staff (126)
- Budgets not sufficient to cover all necessary services (105)
- Lack of reimbursement for services (89)

2. **Staffing and Training Issues:**
    - High staff turnover (72)
    - Lack of general training for staff (22)
    - Lack of training in infection prevention and control (12)

3. **Quality of Care and Service Provision:**
    - Lack of funds for high-quality food for residents (51)
    - Lack of staff time with residents (26)
    - Problems with infection prevention and control (6)
    - Problems with medication management (2)

4. **Regulatory and Compliance Barriers:**
    - Lack of regulatory guidance (23)
    - Lengthy licensing processes (2)
    - Burdensome regulations (2)

5. **Write-In Barriers and Specific Concerns:**
    - Respondents also wrote in specific challenges such as the need for state support in getting resident referrals, consumers' inability, or unwillingness to pay, more support for COVID and personal protective equipment (PPE), a lack of specialized healthcare professionals for smaller facilities, and others